Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN657HOS1	A. BUILDING _____ B. WING _____	03/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENOWN REHABILITATION HOSPITAL	1495 MILL ST RENO, NV 89502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments This Statement of Deficiencies was generated as a result of a State licensure complaint investigation conducted in your facility on 2/3/10 and finalized on 3/3/10, in accordance with Nevada Administrative Code, Chapter 449, Hospitals. Complaint #NV00024371 was substantiated with a deficiency cited. See Tag S 300. A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	S 000		
S 300 SS=G	NAC 449.3622 Appropriate Care of Patient 1. Each patient must receive, and the hospital shall provide or arrange for, individualized care, treatment and rehabilitation based on the assessment of the patient that is appropriate to the needs of the patient and the severity of the disease, condition, impairment or disability from which the patient is suffering.	S 300		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 300	Continued From page 1 This Regulation is not met as evidenced by: Based on record review and staff interview, the facility failed to provide direct supervision to a patient at high risk for fall for 1 of 3 patient records reviewed. (Patient #1) The patient was admitted to the hospital on 8/26/09 following a left above the knee amputation. His diagnoses included severe peripheral vascular disease, chronic obstructive pulmonary disease, history of alcohol abuse, hypertension, anxiety, emotional lability, cachexia and depression. Record review revealed the patient's care plan dated 8/26/09, identified him as being at high risk for injury due to impaired judgement, impaired mobility, impaired coordination and decreased sensation. The interventions identified on the care plan to prevent injury were to educate the patient regarding safety precautions, safety device precautions, safe transfer methods and reinforce the use of appropriate measures to compensate for the client's physical or cognitive deficits. Review of the nurses flow sheets on 8/31/09, revealed the patient was alert, awake but disoriented to time and situation on 8/31/09 at 8:10 AM. The note indicated the patient was very weak and unable to ambulate. He was described as being a high fall risk. A low bed was provided for him, upper bed rails and a bed and chair alarm. His room was close to the nurses station. He had been placed on the Falling Star program. Review of records from 9/1/10 at 10:10 PM revealed the patient continued to be confused to time and situation. He remained at high risk for	S 300		

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S 300	Continued From page 2 falls. He was described as impulsive with poor safety awareness. His upper side rails were in use. Nurses notes written on 9/2/09, revealed that the patient had slept poorly between 11 PM on 9/1/10 and 3 AM on 9/2/10. The patient was disoriented to time and situation and continually asked why he was missing breakfast. The note revealed the patient tried to get out of bed several times during that period of time. The patient was documented to have learned how to turn off the bed alarm and was found out of bed without the alarm sounding. The alarms were put back on and the call light was placed within reach. On 9/2/09 at 5 AM, the patient was found on the floor five feet from his bed. The alarms were turned off again. The patient was disoriented to time and situation. According to the patient's discharge summary of 12/28/09, the patient was found to have a fractured right hip and dehiscence of the left stump with the femur bone protruding following the fall. On 2/5/10, Registered Nurse (RN) #1 was interviewed. She was the nurse responsible for the patient's care on 9/1/09 and 9/2/09. She reported the patient was restless that night and very confused. She stated he learned how to turn the bed alarm off so she moved the alarm as far from him as she could but acknowledged the alarm cord was still in the patient's reach. She placed the call light over his chest. She stated that staff increased the patient's monitoring to every 30 minutes. RN #1 reported the patient calmed down sometime after 3:00 AM and staff were in the patient's room just 20 minutes prior to the fall.	S 300		

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S 300	Continued From page 3 She reported trying to call in an extra staff member in to sit with the patient earlier during her shift but no one was available. She reported that she did not think of getting the patient out of bed so he could be monitored at the nurses station. In a 2/5/10 interview with the Quality Assurance Director, she confirmed staff's attempts to obtain a worker to sit with the patient. She reported that no staff were available to sit with the patient. She did not know if the family was contacted to sit with the patient. She reported that the facility was a restraint free facility and did not use full rails or tie patients down. Staffing on the night of the fall included one charge nurse, two Registered Nurses and three Certified Nursing Assistants for 28 patients. Review of the facility's policy and procedure entitled "Fall Risk Assessment" effective date 3/11/09, revealed that patient safety was an ongoing responsibility of all staff. In order to prevent injury, the RN was to assess the patient risk for falls and institute appropriate interventions. Findings: The complaint is substantiated with a deficiency cited. The facility was aware of the patient's ability to turn of the bed alarm, he got out of bed once and made multiple attempts to get out of bed prior to his fall. Staff acknowledged the patient's need for direct supervision by attempting to arrange for a staff member to sit with the patient. The patient did not receive direct supervision, fell , fractured his right hip and his wound dehisced. Severity: 3 Scope: 1	S 300		